AUTHORIZATION FOR RELEASE OF RECORDS

To: _____ (Name of treatment facility)

_____ (Street address)

_____ (City, state & zip code)

I am being considered for participation in a research program being conducted by the **National Institute of Mental Health** of the NIH. I am hereby authorizing the release of my medical records to the NIMH for any mental health treatment by you or in your facility.

*PLEASE NOTE: **If there have been multiple admissions, please send records for ALL of them.**

Please send the following information to the NIMH:

Admission & discharge summaries	Psychological testing results
ECG, EEG, CT, MRI reports	Medication treatment history
Treatment summaries	Substance abuse treatment history
Consultation reports	Psychosocial history

Any other material that would be relevant for consideration for research studies.

_____ _____
(Signature of patient) (Date)

_____ _____
(Patient's Printed/Typed name) Witness

_____ _____
(Social Security Number) (Date of birth)

_____
(Patient's address)

Materials should be sent **to**:

E. Anne Riley, PhD, MSW
National Institute of Mental Health
Building 10, Room 3C101, MSC1377
Bethesda, MD 20892-1377

Tel:301-594-0874 **T**oll free:1-888-674-6464 **F**ax:301-402-5503
E-mail:anne.riley@nih.gov

This request is covered by the provisions of the Federal Privacy Act. The NIMH will not be responsible for any processing or mailing charges. Any fees must be paid by the requesting individual. Thankyou for your assistance.

THIS RELEASE EXPIRES 1 YEAR AFTER ABOVE DATE OF SIGNATURE